Commentary

Carol Rapaport

These two papers fit together very well, as each concerns poverty's effects on health status. Barbara Wolfe examines whether poor children receive adequate health care. If they do not, these children are more likely to grow up into adults with health problems. Arline Geronimus examines one possible consequence of health problems: excess mortality in people aged fifteen to sixty-four.

My discussion will focus on the health consequences of poverty. I will start by presenting specific comments on each paper and will follow by briefly noting several other public policy concerns relating to health and poverty.

WOLFE

Wolfe asks important questions about children's health. Are children without health insurance receiving adequate care? What are the differences in health expenditures between children with public insurance and children with private insurance? The paper concludes that health insurance coverage and the health status of children have both declined since 1990. In addition, Wolfe argues that by increasing public coverage we will help foster increased equality in health care usage for healthy children—but probably not for children with health problems. I think we would all agree that these are vital policy issues.

Wolfe's paper is also noteworthy for its explicit acknowledgment of data limitations. She uses the most recent data from the Agency for Health Care Policy and Research to evaluate medical expenditures. Unfortunately, the agency has not yet released figures on medical expenditures, and Wolfe is very forthright about the limitations imposed on her argument by this constraint. When her paper talks about expenditures, it is really talking about an index of health care use: the higher the index value, the more the child uses the health care system. The paper is also quite frank about several methodological simplifications.

That being said, two straightforward suggestions could strengthen the paper. First, it would be useful to include the characteristics of the parents. Are they high school graduates? What is their current marital status? These and similar parental characteristics can be expected to affect medical expenditures on children. Second, a look at outcome measures other than expenditures would be worthwhile. For instance, the expenditure data are approximations, but the count data on the number of doctor visits are exact. What, then, is the relationship between

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poverty and the number of doctor visits for infants and toddlers? The American Academy of Pediatrics recommends a certain number of well-baby/well-child visits per year, depending on the child's age. The paper could examine the relationship between poverty and the share of children meeting these minimum requirements.

Wolfe raises two other important questions, but these are much harder to answer. First, what are the interrelationships between poverty, health insurance, and health status? Her paper focuses on children with a health need, but future work could examine need itself. If the United States had something closer to universal coverage, perhaps we would observe fewer children with health problems. Mothers might get better prenatal care, and childhood diseases such as asthma might be detected sooner. Wolfe shows that by increasing coverage we will increase medical usage, but greater coverage might also affect whether an individual child is at high risk for needing a lot of medical care.

The second question is long-standing among economists: why don't all children who are eligible to enroll in Medicaid do so? This question is described as the problem of take-up of public health insurance. Compare two children—one has public insurance, the other is uninsured, healthy, and eligible for public insurance. Just how different are these two children? Quite different, in Wolfe's paper—and in most other research. However, if the uninsured child got sick, went to a clinic, and was immediately enrolled in public insurance, the two children might turn out to be more alike than not. In other words, researchers may need to distinguish an uninsured child who is eligible for public health insurance from one who is not eligible.

Geronimus

This author also addresses an interesting topic: death as an actual health outcome. Such an unambiguous measure of health status is appealing. By analyzing six poor, primarily white communities, and six poor, primarily black communities, Geronimus evaluates excess mortality in men and women aged fifteen to sixty-four. How many black men in a given poor area died, she asks, over and above what would be expected from a national analysis of white men? Her main result is that it is hard to summarize her main results. On the one hand, blacks in poor urban/northern communities have high rates of excess mortality, and the situation is worsening. On the other hand, people in poor rural communities fare better in terms of excess mortality—but the bottom line is that important differences exist across communities.

My suggestions here again are straightforward. First, I am somewhat concerned about the accuracy of the excess mortality measure. Excess mortality is a very conventional measure in health economics, so my concern really applies to all researchers in this area. Excess mortality takes all white men as the optimal health standard for poor black men. Similarly, all white women are assumed to be the optimal health standard for poor black women. My concern is that this procedure implicitly assumes that people of all races are biologically identical. In extreme cases, this assumption is invalid: white individuals are unlikely to get sickle-cell anemia and black individuals are unlikely to get Tay-Sachs disease. Accordingly, I suggest possibly using a standard other than white individuals when evaluating the health of blacks. For example, one might compare black women in poor communities with black women in more affluent ones.

My second suggestion concerns future research. Geronimus has identified poor communities and essentially has sorted them by health status. The paper, however, has not evaluated why the communities are different. I would like to see an analysis of their characteristics. We have learned that health outcomes differ across the communities, but what else is different? The author alludes to the slower pace of southern living, but many additional characteristics of the community—such as education levels—are observable. Moreover, I am especially interested in the supply of health care providers across communities.

Concluding Remarks

There are four issues of current policy importance not fully addressed in these two papers. Each, in my opinion, merits further research. First, in 1997, Congress appropriated funds for individual states to expand public health insurance cover-

age for children. The Children's Health Insurance Program, or CHIP, left the states with great discretion in undertaking this action, and we can expect to see large variations in insurance plans across states. These variations will help researchers examine which types of insurance expansion actually improve health outcomes. However, the eligibility increases may in fact cause children to switch from private insurance to CHIP, a process known as crowding-out.

Second, welfare reform removed the direct link between welfare eligibility and Medicaid eligibility. As some individuals are removed from the welfare rolls, they may not understand that their children remain eligible for public insurance. Third, we know very little about the increasing importance of Medicaid managed care and its effects on health outcomes. Finally, health and the elderly will continue to be an important topic; of particular concern is the fact that the Medicare trust funds will face increasing pressures as the U.S. population ages.